

3. Failure of palliative measures.

4. Express desire of the patient to undergo an operation, after all its dangers and difficulties have been fully explained.—*Lancet*, June 15, 1861, p. 599.

33. *Radical Cure of Inguinal Hernia*.—HOLMES COOTE, Esq., Ass. Surg. St. Bartholomew's, brings forward (*Lancet*, June 1, 1861) some striking facts, to show that Wützer's operation for inguinal hernia cannot be depended on for a permanent cure.

“Those,” he remarks, “who are in the habit of frequenting the wards of St. Bartholomew's Hospital may remember my directing attention in the early part of this year to a case in which I was called upon to operate for the relief of strangulated inguinal hernia on a man on whom I had performed Wützer's operation for the radical cure of hernia three years previously, with apparent success. In this case, as in most others, the inverted plug of integument had come down, and a fibrous constriction of the peritoneal sac remained, which proved the seat of the stricture. I believe this fibrous constriction, in part at least, to have been due to the changes consequent upon the passage of the needle in Wützer's operation, and it had served to keep up the intestine very fairly for above two years and a half. It then yielded, and became the seat of stricture to a protrusion somewhat larger than had ever been before.

“I saw last year a boy on whom I had performed Wützer's operation six months previously. In his case, too, the intestine had come down again; the protrusion was of larger size, and the adaptation of a truss was difficult.

“Under these circumstances, I was induced to ask my friend, Mr. Kingdon, Surgeon to the City of London Truss Society, the results of his experience amongst those who apply to him for trusses, and he favoured me with the subjoined list of cases, which I inclose, with all the details, that any of the surgeons who operated may be able to verify or to contradict their accuracy.

“There can be only one opinion respecting operative surgery. Its only claim is based upon the permanent benefit which it can effect; and if experience proves that any one operation fails, even at a remote period, in its object, it is the duty of those acquainted with the failures to make the facts public, in order that a proper value may be attached to the proceeding.

“CASE 1. Thomas B., aged thirty-five, of Welling, Kent. Ruptured for the first time at the age of thirty-two. Wützer's operation for the radical cure of hernia was performed in St. Bartholomew's Hospital, by Mr. Coote in 1858. Case reported as cured. In 1859 he applied for a truss, at the City of London Truss Society, with oblique hernia on both sides.

“CASE 2. Nathaniel J., aged forty-five, of Phoenix Terrace, an engineer. Operated on in the same way as Case 1, by Mr. Coote, three years and a half ago. He continued well until a few months back. Has applied for a truss, having now hernia on both sides.

“CASE 3. Thomas P., aged thirty, West India Road, Limehouse. He was first ruptured at the age of twenty-eight. The operation for the radical cure was performed by Mr. Corner, of the Poplar Hospital. He applied for a truss, having a scrotal hernia, in 1859.

“CASE 4. John H., aged fifty-one, of Churchway, Somerstown. The operation for the radical cure was performed by Mr. Erichsen. He applied for a truss in 1859.

“CASE 5. James A., aged fifteen, applied for a protecting truss, having just risen from bed after the performance of Wützer's operation. No immediate protrusion.

“CASE 6. John T., aged forty-four, of Duke Street, Westminster Road, bedstead maker. Ruptured at the age of twenty-four. He came for a truss at the Society's house in 1860, being at that time forty-four years of age. He had undergone the operation for the removal of a diseased testis nine months before, by Mr. Coulson, at St. Mary's Hospital. Had hoped that the hernia was cured at the same time. He now (1860) suffers from a large scrotal hernia.

“CASE 7. George C., aged forty-three, of the Broadway, Westminster, gas-fitter's labourer. The operation for the radical cure was performed by Mr. Lee, of King's College. He applied for a truss on Oct. 5th, 1860.

“‘I thought,’ continues Mr. Kingdon (writing to me), ‘and still believe, that I had more of your cases; but the foregoing are those which I can vouch for at present. Two, and I think a third, of Mr. Hutchinson’s have come before me; one also of Mr. Wood’s.’”

34. *Venous Hemorrhage*.—This subject has been very fully discussed by LANGENBECK in the first part of the *Archiv für Klinische Chirurgie*. The causes of difficulty or impossibility of arresting venous hemorrhage are, adhesion of the vein to the neighboring parts; pressure of the column of blood; and regurgitation of the blood. The first mentioned cause of difficulty is especially observed in trephining and in operations for necrosis; and in operations involving the veins of the neck and upper part of the thorax, as the subclavian, external or internal jugular, and axillary. Death may follow wounds of the external jugular vein, even above the point at which it penetrates the cervical fascia. The division of the axillary vein gives rise to unimportant hemorrhage in comparison with the external jugular, because it is but loosely connected with the fascia, while the external jugular is stretched by the fibres of the platysma myoides. Hemorrhage in wounds of the large veins may take place from the peripherie as well as from the eentral end. From the former, the blood flows in a steady stream; from the latter, the bleeding occurs during expiration, or during crying or coughing. Gaping incised wounds of the common jugular vein are fatal, unless immediate surgical aid be at hand. In penetrating wounds of this vein, the blood poured into the sheath may act as a compressing agent and close the orifice; but, if the blood escape into the cellular tissue, a troublesome saignineous tumour is the result. Suppuration, secondary hemorrhage, and pyæmia may also follow punctured wounds of the jugular. Gunshot wounds of the large internal veins, or of the internal jugular, may not give rise to serious bleeding at the time, but are liable to be followed by secondary hemorrhage and thrombus.

Ligation of the corresponding artery is a sure means of arresting hemorrhage from a large vein, as the internal or the external jugular, after compression has been tried and has failed. Hemorrhage from wounds of the external iliac and femoral veins is more troublesome than might be expected from their small size and their distance from the heart. In wounds of the internal jugular, the pressure of the column of blood may be diverted to the vein of the opposite side by compression, in consequence of the free communication through the cranial sinuses; while, in the veins of the lower limb, this cannot be done. The iliac and pleural veins bleed usually from the peripherie end; hence J. Roux has advised ligation of the femoral vein in disarticulation of the thigh. Langenbeck, however, has in six cases observed no hemorrhage from the femoral vein in this operation, although he did not tie the vessel—a proceeding which he considers dangerous.

Dangerous, and even unmanageable venous hemorrhage may be produced by compression of a venous trunk above a wound, by the pressure of a tumour, by obliteration of a vein, or by interference with the pulmonary circulation. In the leg, for instance, venous hemorrhage is not unfrequently produced by the bursting of varicose veins. Hemorrhage from wounded veins, the trunks of which are compressed by tumours, demand ligation of the corresponding artery. Very obstinate also are the capillary venous hemorrhages, dependent on rupture of the small vessels and compression of the venous trunks. Spontaneous hemorrhage from tumours is generally venous or capillary, when it arises from pressure of the vein returning the blood. It occurs most readily in very vascular growths, permeated by enlarged sinuous veins, or constricted at the base by the neighbouring parts. Hemorrhage may occur from internal piles, when they are extruded in defecation and compressed by the sphincter ani; or from polypi of the fauces or of the uterus, when the bloodvessels in them have a cavernous structure. Cirrhosis of the liver sometimes, but very rarely, produces vesical haematuria through obstruction of the inferior cava; generally, however, the gradual development of the cirrhosis allows the establishment of a compensatory circulation through the anastomosing veins.

The fact that the venous hemorrhage in great operations varies with the